

GRIEVANCE OF DISCRIMINATION ON THE BASIS OF DISABILITY AGAINST KING COUNTY, WASHINGTON

This form may be used by a qualified individual with a disability who believes he or she has experienced discrimination based on disability status in admission to, access to and treatment in facilities, programs, services, or activities provided by King County. An authorized representative may file on behalf of a qualified person with a disability. Grievances on behalf of classes of individuals are also permitted. Information requested on this form must be filled out completely to help us expedite processing your grievance.

Please submit your grievance within one-hundred-eighty (180) calendar days of the alleged discriminatory act. OCR will send you a written receipt of your grievance and will forward a copy of this grievance form to the King County Department named as respondent. An OCR Disability Compliance Specialist will be assigned to work on your grievance.

The Disability Compliance Specialist is responsible for facilitation and coordination of responses to disability access grievances. The Specialist is available to provide a variety of services such as coordination of meetings between the parties, technical assistance to the department on requirements, regulations and reasonable accommodations, or other services as requested or deemed appropriate by the department. When a response to a grievance includes work activities with completion dates in the future, OCR will monitor work activities until the activities have been completed.

If the grievant does not agree with the resolution to the grievance proposed by the department, he/she may submit a written request for a different resolution to the manager of OCR within thirty (30) days of the grievant's receipt of the department's response.

You do not need an attorney to file or pursue this grievance with the OCR. However, you may wish to seek legal advice regarding your rights under the law.

Upon request, an alternate format of this form can be made available.

If you need assistance completing this form or have questions regarding rights and protections of the grievance procedure, contact us at:

Please submit this completed form to:

**Office of Civil Rights
Yesler Building, Room 260
400 Yesler Way, MS: YES-ES-0260
Seattle, WA 98104-2683

206-296-7592 Voice
206-296-7596 TTY**

GRIEVANCE OF DISCRIMINATION ON THE BASIS OF DISABILITY
KING COUNTY, WASHINGTON

Grievant Contact Information:

Name

Street address

City

State

Zip code

Work phone #

Home phone #

Message phone #

E-mail address

1. Aggrieved party contact information (if different from grievant):

Name

Street address

City

State

Zip code

Work phone #

Home phone #

Message phone #

E-mail address

2. Name of respondent: King County Government, Washington

3. Department or agency (if known): _____

4. Address/location (if known): _____

5. Date of incident(s) giving rise to this grievance: _____

6. County employees you have dealt with regarding the incident(s) (name, position, agency):

7. Witnesses/others involved (name, address, telephone number)

8. Statement of grievance:
Include all facts upon which the grievance is based (attach additional sheets if needed)

9. Describe how the aggrieved party’s physical and/or mental disability substantially impacts a major life activity.

10. In the grievant's view, what would be the best way to resolve the grievance?

11. Has the grievant filed a lawsuit, complaint, or grievance regarding this matter anywhere else? If yes, give the name and address of each place where you have filed:

I affirm that the foregoing information is true to the best of my knowledge and belief. I understand that all information becomes a matter of public record after the filing of this grievance.

Signature or Mark of Aggrieved Party, and/or

Date

Signature or Mark of Grievant (if different)

Date